PRINTED: 08/12/2015 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E473	B. WING _			07/	27/2011
	ROVIDER OR SUPPLIER	U		128 S F	T ADDRESS, CITY, STATE, ZIP CODE PEARSON AVE RLY, KS 66871		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
F 156 SS=E	health re-survey and 48168. 483.10(b)(5) - (10), 48 RIGHTS, RULES, SE  The facility must infor and in writing in a lan understands of his or regulations governing responsibilities during facility must also provinctice (if any) of the Signal (if any) of the Admade prior to or upor resident's stay. Receany amendments to it writing.  The facility must inforentitled to Medicaid be of admission to the noresident becomes eligitems and services under which the resident may other items and services and services under which the resident may other items and services.	as represent the findings of a complaint investigation #  83.10(b)(1) NOTICE OF ERVICES, CHARGES  In the resident both orally guage that the resident her rights and all rules and gresident conduct and gresident conduct and gresident conduct and gresident with the state developed under st. Such notification must be a admission and during the sipt of such information, and transition to the state developed under st. Such notification must be a cannot during the sipt of such information, and transition and transition facility or, when the gible for Medicaid of the at are included in nursing references that the facility offers ident may be charged, and	F '	156			7/28/11
	inform each resident the items and service (i)(A) and (B) of this s  The facility must infor at the time of admissi	rm each resident before, or ion, and periodically during r services available in the					
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E.		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

08/05/2011

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		17E473	B. WING _		0	7/27/2011	
	ROVIDER OR SUPPLIER	U		STREET ADDRESS, CITY, STATE, ZIP COI 128 S PEARSON AVE WAVERLY, KS 66871			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 156	under Medicare or by  The facility must furni legal rights which inci A description of the right of restablishing eligib the right to request and 1924(c) which determinant the resource institutionalization and spouse an equitable scannot be considered toward the cost of the medical care in his ord down to Medicaid eligible.  A posting of names, and an unbers of all pertine groups such as the Sagency, the State lice ombudsman program.	is for services not covered the facility's per diem rate.  ish a written description of ludes: nanner of protecting personal ph (c) of this section; equirements and procedures illity for Medicaid, including an assessment under section nines the extent of a couple's at the time of a dattributes to the community share of resources which a available for payment a institutionalized spouse's ther process of spending gibility levels.  addresses, and telephone ent State client advocacy state survey and certification ensure office, the State	F1				
	complaint with the St agency concerning re misappropriation of re facility, and non-complainectives requirement. The facility must complete in subpart I related to maintaining procedures regarding	ply with the requirements of part 489 of this chapter					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	CU	1	TREET ADDRESS, CITY, STATE, ZIP CODE 28 S PEARSON AVE VAVERLY, KS 66871	,		
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F 156	concerning the right or surgical treatmen option, formulate an includes a written depolicies to implemer applicable State law.  The facility must infoname, specialty, and physician responsib.  The facility must prowritten information, applicants for admissinformation about he Medicare and Medicare and Medicare refunds for such benefits.  This REQUIREMEN by: The facility reported with 11 selected for observation, record facility failed to prowresidents, on an onrights of the residen.	mation to all adult residents to accept or refuse medical t and, at the individual's advance directive. This escription of the facility's at advance directives and of the dway of contacting the le for his or her care.  In minently display in the facility and provide to residents and sion oral and written ow to apply for and use caid benefits, and how to previous payments covered by the facility and provide to residents and sion oral and written ow to apply for and use caid benefits, and how to previous payments covered by the facility and provide to residents and sion oral and written over the facility and provide to residents and how to previous payments covered by the facility and interview, and interview, the ide information to the going basis, regarding the	F 156				
	subsequent environ approximately 3:00 facility posted the re contacting the state	mental tour, on 7/21/11 at p.m., failed to identify the quired information for ombudsman.					
	The monthly resider	nt council minutes, for the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 156	1 3		F 1	56		
		entify the facility reviewed h the resident council group, eriod of 7 months.				
	with one interviewable identified the staff fail residents attending reany review of the resi would specifically que The resident further in	at approximately 3:00 p.m., e, anonymous resident, to provide information to the esident council meetings with dent rights, unless someone estion that particular right. Indicated the residents ombudsman phone number.				
	review of the resident council meeting and t	reported not aware of any rights during resident he staff would address the taff indicated the facility n for contacting the				
	facility, with an on-goi resdient rights and ac phone number.	rovide the residents of the ing method of reviewing their cess to the ombudsman				
F 221 SS=D	483.13(a) RIGHT TO PHYSICAL RESTRAI		F 2	21		8/9/11
	physical restraints imp	right to be free from any posed for purposes of ence, and not required to edical symptoms.				
	by: The facility reported a	is not met as evidenced a census of 34 residents. cted for review, included 3				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 221	interview, and record ensure freedom from (#17) of the 3 resident restraints  Findings included:  - The 5/3/2011 MDS identified resident #1' included anemia, atriarthritis, anxiety disor and severely impaired assessment also doc a restraint used daily prevents rising.  The current undated of the Merry Walker fipromote independent staff to check with the his/her needs, and to and recliner every 2 h. The 6/14/11, Pre-rest documented the residunsteady on their fee falls, leans backward understand what is be comprehend surround environmental noise words/sounds. Record to continue plan of caupdates, and the next observation on 7/20, resident in the Merry	ts. Based on observation, review the facility failed to physical restraints for 1 hts sampled with physical  (Minimum Data Set)  7 with diagnoses which all fibrillation, hypertension, reder, Alzheimer's disease, do cognitive skills. The umented the resident used identified as a chair which care plan, documented use from 10/1/2009 to present, to be resident often to ascertain reposition between walker mours.  Training assessment dent as alert, disoriented, t, loses balance, a history of level, and misinterprets mmendations documented are with no Plan of Care at evaluation 9/11.	F	221			
	falls, leans backward, understand what is be comprehend surround environmental noise words/sounds. Reco to continue plan of caupdates, and the next observation on 7/20, resident in the Merry	/forward, does not eing said, cannot dings, affected by level, and misinterprets mmendations documented are with no Plan of Care at evaluation 9/11.					

	ND PLAN OF CORRECTION IN IMPER.		I ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E473	B. WING			07/	27/2011
	ROVIDER OR SUPPLIER	eu	•	12	TREET ADDRESS, CITY, STATE, ZIP CODE 28 S PEARSON AVE VAVERLY, KS 66871		
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F 221	Walker down the Earemained seated, and feet, and scooted for sitting on the strap. Or repositioned the resist the Merry Walker to ice cream.  On 7/21/11 at 9:25 and A, assisted their Merry Walker to the resident no longer st Merry Walker alone, beside the resident.  On 7/21/11 at 2:50 F stated they worked a Staff Z, reported the resident walking in the used to do, and explipated their feet to in the floor to scoot it, anot stood up and walker months.  On 7/25/11 at 12:30 the resident no longer Merry Walker, just us added they did not restopped standing to On 7/25/11 at 1:19 F reported they complete they complet	dent moved the Merry st hallway. The resident d moved the walker with their ward on the seat, almost Certified nursing staff DJ, dent at 2:10 PM, and pushed the dining room for cake and AM, certified nursing staff D esident to transfer from the toilet. Staff A stated, "The ands and walks with the usually only when staff walks AM, certified nursing staff Z, at the facility for over 2 years. If the facility for o	F	2221			

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		17E473	B. WING_	B. WING		07/	27/2011
NAME OF PROVIDER OR SUPPLIER  COFFEY COUNTY HOSPITAL LTCU			128 S	T ADDRESS, CITY, STATE, ZIP CODE PEARSON AVE ERLY, KS 66871			
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F 221	not need a therapist of therapist does come facility, but no therapy the Merry Walker is the The resident no longe the merry walker, that walking beside the way was the best assistive. The resident would jurplaced in a wheelchat the resident in a wheel merry walker or since standing and walking.  The facility May 2011 stated:  "To continually reasses status to determine the requiring restraint confunctional status is reanot restraint use, and monitored; no unantice."	e for the resident, and does evaluation to tell them that. A in once a week to the y screens for him/her, to say ne least restrictive device. Er stood up and walked in the/she did walk with staff talker, and felt the walker e device for the resident. Ist have increased falls if ir. The facility had not tried elchair since going to the to the resident had stopped	F2	221			
F 226 SS=D	free from a physical repurpose of convenier to treat the resident's 483.13(c) DEVELOP/ABUSE/NEGLECT, E  The facility must deve policies and procedur	MMPLMENT ETC POLICIES  elop and implement written res that prohibit t, and abuse of residents	F2	226			7/28/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	(X3) DATE SURVEY COMPLETED			
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F 226	Continued From page	e 7	F 22	26		
	by: The facility reported Based on observation review, the facility fai of certification for one	r is not met as evidenced a census of 34 residents. n, interview and record led to complete verification e of 5 staff members aployment of the certified				
	administrative staff L aide registry verification	nent records, on 7/19/11 with , identified a lack of nurse ion for one CNA (certified e, with a hire date of 3/8/11.				
	Interview on 7/21/11 administrative staff L the registry before en	, reported, "I usually contact				
	"The Director of Lo Human Resources D ensure all potential e history of abuse and/ record:Certification	estigation/Action, identified, ng Term Care and the irector of [the facility] will mployees are screened for				
	facility remained free when staff failed to ve eligibility for one certi	ensure the residents of the from abuse of neglect, erification employment ified staff member from period of 4 months and 12				
F 241 SS=D	483.15(a) DIGNITY A INDIVIDUALITY	AND RESPECT OF	F 24	11	8/9/11	

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		17E473	B. WING	<del></del>	,	07/27/2011
	ROVIDER OR SUPPLIER	ะบ		STREET ADDRESS, CITY, STATE, ZIP CODE  128 S PEARSON AVE  WAVERLY, KS 66871	·	
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F 241	Continued From pag	e 8	F 24	41		
	manner and in an en	mote care for residents in a vironment that maintains or lent's dignity and respect in or her individuality.				
	by: The facility identified with 11 residents san observation, interview facility failed to speal	I is not met as evidenced I a census of 34 residents Inpled. Based on I w and record review, the I k in a respectful manner that I one sampled resident (#12).				
	Finding included;					
	admitted resident #1: Physician's Order Sh	cholesterolemia,				
	Protocol summary, d resident required mir	ecent Resident Assessment ated 9/30/10, recorded the nimal to moderate assistance for all activities of daily living cits.				
	3.0 assessment, date resident with a Brief (BIMS) score of (1) the impaired cognition, a with short and long-to-	rly Minimum Data Set (MDS) ed 6/14/11, recorded the Interview for Mental Status hat indicated severely nd documented the resident erm memory impairment, decision-making and staff ities of daily living.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED	
		17E473	B. WING		07/27/2011	
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F 241	Continued From pag	e 9	F 24	<b>41</b>		
	6/21/11, lacked evide "nickname" or name  Observation during p	nt's plan of care, dated ence the resident preferred a other than his/her own.  personal cares on 7/21/11  30 P.M., revealed direct care				
	staff B and J respond "Babe" or "Honey" a failed to call the resid The resident stated '	ded to the resident using minimum of 10 times and dent by his/her given name. 'don't put me in this water", sponded and said, "Oh, I				
	In response to the re	sident stating, "I'm freezin", nsoled the resident and said, w you're cold."				
		.M., direct care staff F up from the dining table and Honey".				
	1	A.M., licensed nursing staff I, ldress residents by their				
		P.M., direct care staff D t preferred to be addressed				
		P.M., direct care staff F, t preferred to be called by				
	administrative staff L refer to residents by name and the reside	on 7/25/11 at 2:00 P.M., revealed that staff should the resident's preferred nt's plan of care should different than the resident's				

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		17E473	B. WING			07/	27/2011
	ROVIDER OR SUPPLIER	U		1	TREET ADDRESS, CITY, STATE, ZIP CODE 28 S PEARSON AVE VAVERLY, KS 66871		
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F 241 F 253 SS=E	Resident Rights, doci has a right to a dignif facility must protect a each resident.  The facility failed to e resident in a manner enhanced the resider individuality.  483.15(h)(2) HOUSE MAINTENANCE SER	provided undated policy, umented that the resident ied existence,and the nd promote the rights of surface staff addressed this of their choice of name, that int's dignity, respect and surface wide housekeeping and surface necessary to maintain a		241			8/25/11
	by: The facility reported Based on observation review the facility faile and homelike environ facility in 2 of 2 halls a Findings included: - Maintenance staff \( \) confirmed the followin and fixtures in the res repair or replacement West Hall:  1. Four resident 's p						

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F 253	brown stain on the t  2. The ceiling tile a hallway, exhibited d	ge 11 ille, at the base of the toilets. above the air conditioner in the iscoloration and a dark ubstance on the surface.	F 253			
	caulking, with holes window. Another read cracked moldin Another resident 's caulking around the plastic trim around to 2. One resident 's trim around the unit exhibited loose and the air conditioner unit conditioner unit conditioner unit conditioner unit as urrounding the air non-sanitizable surf.  3. The ceiling tile a	room air conditioner lacked  . Another resident room peeling paint on the edges of init. Another resident room 's exhibited bare wood conditioner unit, creating a face.  bove the air conditioner in the ited a discoloration on the tile				
	use for resident 's # and discolored shee legs of the units. A old faded material, of frayed edges, hang	ved merry walker 's, noted in # 17 and 33, exhibited soiled ep skin padding to the lower dditionally, the units exhibited cut at irregular angles, with ing from the bottom rails. tenance staff Y, indicated at				

NAME OF PROVIDER OR SUPPLIER  COFFEY COUNTY HOSPITAL LTCU  STREET ADDRESS, CITY, STATE, ZIP CODE  128 S PEARSON AVE  WAVERLY, KS 66871   (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 253  Continued From page 12  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  128 S PEARSON AVE  WAVERLY, KS 66871  PROVIDER'S PLAN OF CORRECTIVE PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIATE OF THE APPR	) BE COMPLETION
COFFEY COUNTY HOSPITAL LTCU  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE CROSS-	) BE COMPLETION
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F 253 Continued From page 12	
that time, the items contained weights to counterbalance the units for safety.  2. During the outside tour, observation revealed 6 white trash bags of aluminum cans, sitting outside the kitchen door. Interview, at that time with Environmental staff P, indicated the staff collected the cans for recycling.  The facility failed to maintain a clean and sanitary environment for the residents of the facility.  F 272 483.20(b)(1) COMPREHENSIVE  SS=D  ASSESSMENTS  The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications;	8/25/11

	MENT OF DEFICIENCIES AN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 272	the additional asses areas triggered by t Data Set (MDS); an	and procedures; ; ummary information regarding ssment performed on the care he completion of the Minimum	F 2'	72		
	by: The facility reported with 11 selected for observation, intervie facility failed to thord 37, 4, and 17) for addily living), and restrictions included:  The facility admitt with diagnoses included obstructive chronic esophageal reflux, remellitus, type II, dephyperlipidemia, card persistent mental differential discontinuous assessment, da resident with bims (status) score of 11 (status)	ed resident # 37 on 7/13/10, uding vascular dementia, bronchitis, atrial fibrilation, myocardia infarction, diabetes pression, hypertension, diovascular disease and				

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F 272	dated 6/28/11, identified for falls, scoring risk). The CAAS fur are assessed and the effects that appear is have been 3 falls sificated to investigate contributions to falls the staff developed to prevent further act A Fall Risk Assessm (with 10 or greater in The undated, "TOT plan, identified, "Sic changes by self, train with gaitbelt pring (as and wheelchair."  On 7/25/11 at appronursing staff M, lack nodded his/her hear causal factors the since it is fall risk.  The facility failed to	rea Assessment Summary), tified the resident as a high g 16 (with 10 or greater at high rither indicated, "Medications here are no adverse side to contribute to a fall. There noce last annual." The CAAS //identifiy all causal factors for a for this resident, to ensure a comprehensive care plan, ecidents for this resident.  The CAAS //identifiy all causal factors for a comprehensive care plan, ecidents for this resident.  The CAAS //identifiy all causal factors for this resident, to ensure a comprehensive care plan, ecidents for this resident.  The CAAS //identifiy all causal factors for this resident.  The CAAS //identifiy all causal factors for this resident, to ensure a comprehensive care plan, ecidents for this resident.  The CAAS //identifiy all causal factors for this resident, to ensure a comprehensive care plan, ecidents for this resident.	F 272		
	Diagnoses included (cerebral vascular a	red resident # 4 on 5/28/02. I, duodenal ulcer, cva accident), hypertension, ty, dysphagia, depression, ipation.			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		17E473	B. WING		07/27/2011
	ROVIDER OR SUPPLIER	cu	1:	TREET ADDRESS, CITY, STATE, ZIP CODE 28 S PEARSON AVE VAVERLY, KS 66871	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 272	comprehensive res 8/17/10, identified to flong and short te of decision making resident required to (activities of daily limited to flow the contribution of the case of the contribution	ident assessment, dated he resident as not assessable arm memory, severely impaired skills, and identified the stall staff dependence for adl's ving).  ea assessment summary), sified the resident as for all adl's except eating. Identification of causal factors, resident's dependency on staff comprehensive care planning.  all Plan of Patient Care, "Ithe resident required a y and transferred with a 2 staff assistance.  Eximately 5:15 p.m., licensed ked comment, although did when questioned what staff had identified for this ince of adl needs.  Thoroughly assess the causal dent's dependence on staff for	F 272		
	identified the reside included anemia, a	S (Minimum Data Set) ent with diagnoses which trial fibrillation, hypertension, order, Alzheimer's disease,			

. ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE S COMPL	
		17E473	B. WING _			07/2	27/2011
	ROVIDER OR SUPPLIER	U		STREET ADDRESS, CITY, STATE, 2 128 S PEARSON AVE WAVERLY, KS 66871	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIAT CIENCY)		(X5) COMPLETION DATE
F 272	Continued From page	e 16	F 2	272			
	and severely impaired assessment also doc a restraint daily, ident prevents rising.  The current undated of the Merry Walker fipromote independent staff to check with the his/her needs, and to and recliner every 2 h. The 6/14/11, Pre-rest documented the residunsteady on their fee falls, leans backward, understand what is be comprehend surround environmental noise I words/sounds. Reco	d cognitive skills. The umented the resident used tified as a chair which care plan, documented use rom 10/1/2009 to present, to be. The care plan instructed e resident often to ascertain reposition between walker nours.  Training assessment dent as alert, disoriented, t, loses balance, a history of forward, does not being said, cannot dings, affected by level, and misinterprets mmendations documented are with no Plan of Care					
	resident in the Merry	/11 at 1:35 PM , revealed the Walker in the hallway, eyes d down in the seat and with dent moved the Merry					
	remained seated, and feet, and scooted for sitting on the strap. C repositioned the resid	t hallway. The resident d moved the walker with their ward on the seat, almost certified nursing staff DJ, dent at 2:10 PM, and pushed he dining room for cake and					
	and A, assisted the re	M, certified nursing staff D esident to transfer from the oilet. Staff A stated, "The					

RECTION	IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E473	B. WING		07/27/2011
	cu	1	28 S PEARSON AVE	1 3772772311
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
dent no longer s ry Walker alone ide the resident.  7/21/11 at 2:50 f ed they worked a f Z, reported the dent walking in t d to do, and exp hed their feet to  7/25/11 at 10:30 orted the resider the Merry Walk floor to scoot it, stood up and wa hths.  7/25/11 at 12:30 resident no long ry Walker, just u ed they did not r oped standing to  7/25/11 at 1:19 f orted they comple essment quarter at restrictive devi need a therapist apist does com ity, but no thera Merry Walker is resident no long resident no long ry Walker is	etands and walks with the , usually only when staff walks  PM, certified nursing staff Z, at the facility for over 2 years. By had not witnessed the the merry walker alone as they olained the resident now just move the Merry Walker.  AM, certified nursing staff T, and no longer stood and walked their just moved their feet over and stated the resident had alked with it for several  PM, licensed staff K, stated ger stood to walk with the used their feet to move it, and remember when the resident of walk with it.  PM, licensed nursing staff M, lete the pre-restraining by. "The Merry Walker is the ice for the resident, and does to evaluation to tell them that. A the in once a week to the pry screens for him/her, to say the least restrictive device.	F 272	,	
	summary signal processing to the processing to the standing to	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Itinued From page 17 Ident no longer stands and walks with the ry Walker alone, usually only when staff walks ide the resident.  7/21/11 at 2:50 PM, certified nursing staff Z, ed they worked at the facility for over 2 years. If Z, reported they had not witnessed the Ident walking in the merry walker alone as they Ident to do, and explained the resident now just hed their feet to move the Merry Walker.  7/25/11 at 10:30 AM, certified nursing staff T, orted the resident no longer stood and walked the Merry Walker, just moved their feet over floor to scoot it, and stated the resident had stood up and walked with it for several hiths.  7/25/11 at 12:30 PM, licensed staff K, stated resident no longer stood to walk with the ry Walker, just used their feet to move it, and ed they did not remember when the resident hyded standing to walk with it.  7/25/11 at 1:19 PM, licensed nursing staff M, orted they complete the pre-restraining bessment quarterly. "The Merry Walker is the it restrictive device for the resident, and does heed a therapist evaluation to tell them that. A apist does come in once a week to the ity, but no therapy screens for him/her, to say Merry Walker is the least restrictive device. resident no longer stood up and walked in	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Itinued From page 17 Ident no longer stands and walks with the ry Walker alone, usually only when staff walks ide the resident.  7/21/11 at 2:50 PM, certified nursing staff Z, ed they worked at the facility for over 2 years. If Z, reported they had not witnessed the dent walking in the merry walker alone as they did to do, and explained the resident now just hed their feet to move the Merry Walker.  7/25/11 at 10:30 AM, certified nursing staff T, orted the resident no longer stood and walked the Merry Walker, just moved their feet over floor to scoot it, and stated the resident had stood up and walked with it for several hths.  7/25/11 at 12:30 PM, licensed staff K, stated resident no longer stood to walk with the ry Walker, just used their feet to move it, and ed they did not remember when the resident uped standing to walk with it.  7/25/11 at 1:19 PM, licensed nursing staff M, orted they complete the pre-restraining sesment quarterly. "The Merry Walker is the it restrictive device for the resident, and does need a therapist evaluation to tell them that. A apist does come in once a week to the ity, but no therapy screens for him/her, to say Merry Walker is the least restrictive device.	STREET ADDRESS, CITY, STATE, ZIP CODE  128 S PEARSON AVE  WAVERLY, KS 66871  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  Intinued From page 17  dent no longer stands and walks with the ry Walker alone, usually only when staff walks ide the resident.  7/21/11 at 2:50 PM, certified nursing staff Z, ed they worked at the facility for over 2 years.  1Z, reported they had not witnessed the dent walking in the merry walker alone as they do not one and the resident now just head their feet to move the Merry Walker.  7/25/11 at 10:30 AM, certified nursing staff T, orted the resident no longer stood and walked the Merry Walker, just moved their feet over floor to scoot it, and stated the resident had stood up and walked with it for several this.  7/25/11 at 1:19 PM, licensed staff K, stated resident no longer stood to walk with the ry Walker, just used their feet to move it, and ed they did not remember when the resident ped standing to walk with it.  7/25/11 at 1:19 PM, licensed nursing staff M, orted they complete the pre-restraining sessment quarterly. "The Merry Walker is the trestrictive device for the resident, and does need a therapist evaluation to tell them that. A apist does come in once a week to the tity, but no therapy screens for him/her, to say Merry Walker is the least restrictive device. resident no longer stood up and walked in

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		17E473	B. WING			07/	/27/2011
	ROVIDER OR SUPPLIER	IJ		12	TREET ADDRESS, CITY, STATE, ZIP CODE 28 S PEARSON AVE (AVERLY, KS 66871		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 272	standing and walking The facility, May 201 stated: "To continually reasses status to determine the requiring restraint confunctional status is resolved in the restraint use, and monitored; no unanticoccurring and benefits risks."  The facility failed to proceed for the Merry W. 483.20(d)(3), 483.10(participate in planning changes in care and for the resident has the incompetent or otherwincapacitated under the participate in planning changes in care and for the resident, and comprehensive assessinterdisciplinary team physician, a registere for the resident, and codisciplines as determined and, to the extent pratter resident, the resident representative; as the state of the resident, the resident representative; as the state of the resident, the resident representative; as the state of the resident, the resident representative; as the state of the resident, the resident representative; as the state of the resident representative; as the resident representative representative.	the resident had stopped in the Merry Walker."  1, Physical Restraint Policy ess the resident's functional nat the medical condition of tinues, that any decline in lated to medical condition, that negative effects are sipated negative effects are signated negative effects are sident's current physical erform daily activities and the alker as an assistive device. k)(2) RIGHT TO NING CARE-REVISE CP right, unless adjudged wise found to be the laws of the State, to g care and treatment or treatment.		272			8/25/11

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		17E473	B. WING		07/27/2011
	ROVIDER OR SUPPLIER	:u		STREET ADDRESS, CITY, STATE, ZIP CODE  128 S PEARSON AVE  WAVERLY, KS 66871	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	D BE COMPLETION
F 280	Continued From pag each assessment.	e 19	F 28	0	
	by: The facility reported with 11 selected for sobservation, intervier facility failed to review selected residents (#Findings included:  - The facility admitted A, 7/7/08, Initial Activation activity assessment identified the resident activities in the afterrorafts/arts, sports, more television, gardening and groups.  The "Total Plan of Paidentified the resident however, failed to identified the resident might attended to the resident might attended to the resident might attended to the resident most resident might attended to the resident most resident might attended to the resident might attended to the resident most resident might attended to the resident most resident might attended to the resident most resident mo	and resident # 28 on 7/3/08.  Wity Assessment (The only in the clinical record) in the clinical record) in the referred to attend in oon, enjoyed cards, games, usic, reading, writing, in it required escort to activities, entify activities which the interest in the resident short term memory and decision making skills. The indentified the resident activity is receiving shower, family or significant others ussions, listening to music,			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF COMPLET			
		17E473	B. WING			07/	27/2011
	ROVIDER OR SUPPLIER	· ·		1	TREET ADDRESS, CITY, STATE, ZIP CODE 28 S PEARSON AVE VAVERLY, KS 66871		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280	Review of the April, I logs, identified the rein television, one to occasional party.  Observation at internibithday party, bingo the days of survey, 7 identify the resident at the dependent on staff for activities, related to have a compared to the resident participal some special events activity personnel. The does not enjoy large the resident participal some special events activity personnel. The resident personnel is month, along with small group activities. Interview on 7/25/11 nursing staff I, report attends activities, fur issues and the length tolerated being up in On 7/25/11 at approximate activity staff N, received only the initial received in the resident participal staff is the resident participal staff in the resident participal staff is the resident	May and June 2011 activity sident typically participated one's, family visits, and an inittent activities, (such as a a and special outing) during /19/11 to 7/21/11 failed to attended activities.  a.m. CNA (Certified Nurse a resident as totally or cares, and did not enjoy hearing difficulties.  21/11 at 9:30 a.m., reported the totally or cares, and the extent possible in a enjoyed one to one's with the staff reported the resident groups much anymore.  activity logs, for April, May diffied the resident had been a sapproximately 15 times he some other additional is.  at 1:30 p.m. with licensed the resident rarely ther citing skin integrity in of time the resident.	F	280			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		17E473	B. WING	<del></del>	07/27/2011
	ROVIDER OR SUPPLIER	cu	12	TREET ADDRESS, CITY, STATE, ZIP CODE 28 S PEARSON AVE /AVERLY, KS 66871	·
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 280	MDS for an activity a initial assessment.)  The facility failed to resident's plan of ca resident declined an participate in activitie. The direct care staff resident's activity profailure to review and Therefore, the facility resident to activity grant of the state of the stat	review and revise the re for activities, as the d lacked the ability to revise the performance of choice, independently. I lacked knowledge of the references as a result of this revise the plan of care. The plan of care of the revise the plan of care. The plan of care of the revise the plan of care. The plan of care of the revise the plan of care of the revise the plan of care of the revise the plan of care. The plan of care of the revise the plan of the revise the plan of the revise	F 280		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		17E473	B. WING		07/27/2011
	ROVIDER OR SUPPLIER	cu	1	TREET ADDRESS, CITY, STATE, ZIP CODE 28 S PEARSON AVE VAVERLY, KS 66871	·
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRODECTION OF THE APPRODES OF THE APPROPRIES OF THE APPRODES OF THE APPRODES OF THE APPROPRIES O	JLD BE COMPLETION
F 280	reported the residen morning, and determ talked to the night not check the alarms more stated the facility do with each fall/incider intervention if it is posomething to write it.  The 3/15/11 nurses's documented "The resident documented "The resident said "Slipped bed alarm, when in land physician inform.  The 7/19/11 5:15 AN " The nurse called to resident sitting on the upright beside them. The fall unwitnessed injuries; Resident palarm on. VS 179/86 62,18,02 93%."	eM, licensed nurse M, at did have a fall Tuesday nined the alarm was off. Staff urse and this nurse plans to be frequently. Staff also es not add a new intervention at and said," We only do an ertinent. We do not just add a down."  Is notes, (no time) esident found awake sitting on sident's back leaning against oms of injury noted, and the ed off bed" initiated day time bed neuro checks began, son ned."  In nurse's notes documented; or room, and observed er floor at bedside with walker. The resident very confused. It, neuros started, no noted but back to bed, bed low, bed is, sitting 165/76, 98.1,  120 PM, certified nursing staff dent does not use the bed	F 280		
	reported the bed ala not during the day ti On 7/25/11 at 2:05 F stated the intervention	PM, licensed nursing staff K, arm is only used at night time me when he lays down.  PM, licensed nursing staff M, on for the fall on 3/15/11 at the bed alarm on during the			

	EMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		17E473	B. WING			07/	27/2011
	ROVIDER OR SUPPLIER	U	•	1	TREET ADDRESS, CITY, STATE, ZIP CODE 28 S PEARSON AVE VAVERLY, KS 66871		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280	•	e 23 evise the care plan with the on to include the time when	F	280			
F 309 SS=D		e bed alarm on the resident. RE/SERVICES FOR	F	309			8/9/11
	provide the necessary or maintain the higher mental, and psychoso	eceive and the facility must y care and services to attain st practicable physical, ocial well-being, in comprehensive assessment					
	by: The facility reported a with 11 residents sam and record review, the necessary care and s	is not met as evidenced a census of 34 residents, held. Based on interview, e facility failed to provide the hervice related to following a #24) of the 11 sampled					
	Findings included:						
		cian order, instructed staff to 0 milligrams, by mouth daily ant.					
	Set) identified resider included congestive r fatigue, anxiety disord narcolepsy., and cand	2011 MDS (Minimum Data nt #24 with diagnosis which neart failure, hypertension, der, anemia,hypothyroidism, cer without metastasis,with a for Mental Status) score of					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		17E473	B. WING _		07	/27/2011	
	ROVIDER OR SUPPLIER	J		STREET ADDRESS, CITY, STATE, ZIP CODE  128 S PEARSON AVE  WAVERLY, KS 66871			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 309	On 5/31/11, the pharm documented; "From of Megace has helped enjoyment. The residually diet intake is 75-Megace could be discomaintain appetite with The physician returner and ordered to discomaintain appetite with The physician returner and ordered to discomaintain appetite with The physician returner and ordered to discomaintain Admitted facility staff continus Megace 40 millligrams to the resident.  On 7/25/11 at 2:55 PN the letter from the physician currently recommon form of the staff over the staff over the staff over the facility failed to form of 6/25/11 to discontinus the Megace 40 milligram to the staff over the facility failed to form of 6/25/11 to discontinus the Megace 40 milligram to the staff over the	nacy consultant staff dietary notes 3/3/11, the use d patient with diet intake and lent's weight is stable and downward to see if they nout the drug." dot the letter signed 6/25/11, ntinue the medication.  O11 and July 2011, ninistration Record) revealed ued to administer the s, daily from 6/26-7/25/2011  M, licensed nurse I, verified visician ordered the facility ne Megace, and the eived the medication  M, licensed nurse K, erlooked the physician order gace  ollow the physician's order nue the medication for 30 y the surveyor. ACCIDENT SION/DEVICES  ure that the resident		323		8/19/11	
	environment remains as is possible; and ea	as free of accident hazards					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E473	B. WING			07/	27/2011
	ROVIDER OR SUPPLIER	U		1	STREET ADDRESS, CITY, STATE, ZIP CODE 128 S PEARSON AVE WAVERLY, KS 66871		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page prevent accidents.	e 25	F	323			
	by: The facility reported a Based on observation failed to maintain a sa residents of the facilit the 24 resident rooms failed to ensure safet staff failed to impleme alarm, as planned.  Findings included:  - During environment 7/21/11 at 11:20 AM,	a census of 34 residents. In and interview, the facility afe environment for the by in 2 of 2 halls and in 15 of by Additionally, the facility by for resident #8, when the bent use of a personal body  tal tour of the facility on with maintenance staff Y, the following resident areas					
	6 of the 12 resident ro contained chair rails, rooms. These chair redges, with gouges ir splintered edges. Fu contained multiple so the wood and not flus These chair rails crea any resident that may staff Y confirmed the repair.	nt rooms on the east hall and coms on the west hall which encircled most of the rails contained uneven in the wood, which created rethermore, the chair rails rews which protruded from which with the wood surface. In the wood surface we touch them. Maintenance the hazards and the need for					
	2. Two of the 12 room contained sharp edge	ns on the west hall, es on the window trim. Staff					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		17E473	B. WING		07/27/2011	
	ROVIDER OR SUPPLIER	eu		STREET ADDRESS, CITY, STATE, ZIP CODE 128 S PEARSON AVE WAVERLY, KS 66871		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 323	Continued From pag Y confirmed the nee		F 323	3		
		maintain a safe and homelike residents of the facility.				
	resident # 8 with diag dementia, hypertens constipation, depress chronic obstructive p BIMS (Brief Inventor 4(score of 0-7 indica cognition). The asse resident required lim	Minimum Data Set) identified gnoses which included ion, congestive heart failure, sion, macular degeneration, ulmonary disease, and a y of Mental Status) score of tes severely impaired ssment further identified the ited assistance from 1 staff living, and 1 fall with minor				
	)included the resider falls since the last ar occurred in the bedi	are Area Assessment at experienced 2 non-injury anual assessment. Both falls coom while the resident and go to the bathroom.				
	unsteady gait, impair assistance with toiler ambulate. It further	I the staff the resident had an red judgement, required staff ing, and used a walker to instructed staff that the alarm, but failed to instructed				
	bed with eyes close hung on the left side	AM, the resident lay on the d, with an alarm observed of bed, with no lights on it.  M, certified nursing staff V,				
	stated," The resident times when in bed, s	thas a bed alarm, on at all taff know the alarm is on by ht." He/she picked the alarm				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		17E473	B. WING			07/	27/2011
	ROVIDER OR SUPPLIER	J	•	1	TREET ADDRESS, CITY, STATE, ZIP CODE 28 S PEARSON AVE VAVERLY, KS 66871		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	not on now, the light is reported, "The reside the facility with a rolled turn the alarm off when they sometimes forgeresident experienced when the last one was On /21/11 at 9:15 AM. The resident is to have when he/she is in becommand with the last one was when he/she is in becommand with the last one was when he/she is in becommand with the last one was when he/she is in becommand with the last one was when ambulat Tuesday morning, with interventions are additionable control of the last one of the E. On 7/25/11, at 1:20 Pl reported the resident in the daytime, only a On 7/25/11 at 1:59 Pl reported the bed alarm not during the day time. The facility failed to example the facility failed to example the side of the facility failed to example the side of	yor, and stated, "Well it is is not showing" He/she, ent is able to ambulate about it walker, said the staff will en the resident gets up, and et to turn it back on. The falls but I can't remember is."  I licensed nurse G, stated."  The tee the bed alarm at all times it. The resident uses a roller ing, and had a fall this past thout injury, and new it ed to the care plans, by the director of Nursing."  M, certified nursing staff D, does not use the bed alarm it night.  M, licensed nursing staff K, is only used at night time it when he/she lays down censed nursing staff M, on for the fall on 3/15/11 at the bed alarm on during the well as during the planned	F	323			
F 329 SS=E	further accidents. 483.25(I) DRUG REG UNNECESSARY DR	resident with falls, to prevent SIMEN IS FREE FROM UGS regimen must be free from An unnecessary drug is any	F	329			8/12/11
	, 5	, 5					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E473	B. WING	·	07/27/2011
	ROVIDER OR SUPPLIER	U		STREET ADDRESS, CITY, STATE, ZIP CODE  128 S PEARSON AVE  WAVERLY, KS 66871	·
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION
F 329	duplicate therapy); or without adequate mo indications for its use adverse consequence should be reduced or combinations of the resident, the facility resident, the facility resident, the facility resident and the second and do record; and residents drugs receive gradual behavioral intervention	cessive dose (including for excessive duration; or nitoring; or without adequate growth; or in the presence of es which indicate the dose discontinued; or any easons above.  The ensure that residents an ensure that residents not less antipsychotic drug to treat a specific condition cumented in the clinical so who use antipsychotic and dose reductions, and	F 32	9	
	by: The facility identified with 11 residents san and record review, th 10 residents reviewe unnecessary medica parameters for monit #9 that received two monitoring the blood duplicative blood premonitoring for advers	a census of 34 residents appled. Based on interview e facility failed to ensure 9 of d for medications were free tions that included oring the pulse for resident cardiac medications and pressure of resident #27 on ssure medications and se side effects on Black Box ts (# 4, 8, 9, 12, 17, 27, 28,			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED		
		17E473	B. WING		07	7/27/2011
	ROVIDER OR SUPPLIER	U	,	STREET ADDRESS, CITY, STATE, ZIP CODE  128 S PEARSON AVE  WAVERLY, KS 66871	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 329	admitted resident #9, Review of the Physic June 2011, recorded hypertension, atrial-fic congestive heart failu disease, erosive esop of myocardial infarction Review of the Medica (MAR), dated July 20 orders that included: daily for hypertension 0.125 milligrams daily (dated 1/15/10), Lasix daily in the morning for (dated 7/24/09), Tylen with Ultram (a pain m Noon for arthritis (dat milligrams, 2 tablets a (dated 4/2/08).  The plan of care, date resident received Lasit the resident's plan of Black Box Warning for effects of Lasix or Tyl  According to the FDA Administration) MedV recorded "A Boxed W potential for severe live	nical record, the facility on 9/19/05.  san's Order Sheet, dated diagnoses that included brillation, arthritis, re, gastroesophageal reflux phagitis, constipation, history on and hemorrhoids.  stion Administration Record 11 documented physician Toprol XL, 12.5 milligrams, and (dated 4/2/08); digoxin, and for congestive heart failure (furosemide), 60 milligrams for congestive heart failure and 500 milligrams, 1 tablet edication) at 8 A.M. and the edication and Tylenol, 500 at bedtime for arthritis pain and the edication of the e	F 32	29		
	(swelling of the face,	tial for allergic reactions mouth, and throat, difficulty rash) for acetaminophen.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E473	B. WING		07/27/2011	
		-cu	1	STREET ADDRESS, CITY, STATE, ZIP CODE 128 S PEARSON AVE NAVERLY, KS 66871		
PRÉFIX	(EACH DEFICIEI	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 329	According to Lexi-C for Nursing, 12th Edu (U.S. Boxed Warning given in excessive to other loop diuret diuresis, resulting in depletion.  On 7/21/11 at 3:00 revealed the consumedications, advertacility an entire list Warnings.  Review of the facility resident care plantablack Box Warning and Lasix (furosem The clinical record received the Toprolas ordered.  The clinical record received the Toprolas ordered.  The resident's pulse price Toprol or digoxin.  During an interview licensed nursing stanot aware the residents pulse price Toprol XL or digoxin.	comp Information Handbook dition, page 649, recorded a ang) for Lasix (furosemide), if amounts, furosemide, similar ics, can lead to profound in fluid and electrolyte  P.M., licensed nursing staff M lting pharmacist reviewed all se reactions and provided the of medications with Black Box ity listed medications in the pooks, lacked evidence of the for Tylenol (acetaminophen) ide).  documented the resident XL, Digoxin, Lasix and Tylenol revealed staff documented the or to administration of the  R/clinical record lacked an parameters for staff dent's pulse for the Toprol or  on 7/25/11 at 1:15 P.M., aff M reported that he/she was	F 329			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		17E473	B. WING		07/27/2011
		STREET ADDRESS, CITY, STATE, ZIP CODE  128 S PEARSON AVE  WAVERLY, KS 66871			
PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COMPLETION
F 329			F 329		
	standing orders, and	d staff use the "standard" for			
	reported the facility medication digoxin	parameter for holding the			
	documentation infor directed staff to repo	mation labeled KDHE Physer, ort a resting pulse less than			
	parameters for the rate with administra	nonitoring of resident heart tion of medications for			
	parameters for this	resident that received two			
	medication was free medication by failure	from unnecessary e to identify and monitor			
		lity face sheet, recorded the dent #27 on 1/16/08.			
	June 2011 and sign 6/15/11, recorded di dementia, hypertens	cian's Order Sheet, dated ed by the physician on agnoses that included: sion, osteoporosis, coronary ession and age-related on.			
	Review of the Care	Area Assessment (CAA),			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E473	B. WING		07/27/2011	
	ROVIDER OR SUPPLIER	-cu		STREET ADDRESS, CITY, STATE, ZIP CODE  128 S PEARSON AVE  WAVERLY, KS 66871		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 329	independent with divided resident with a Brie (BIMS) score of (8) impaired cognition assistance from state Review of the resident with a Brie (Parket William) assistance from state Review of the resident resident with a Brie (Market William) and the pisodes.  Review of the Medic (Market William) and the pisodes.  Review of the Medic (Market William) and the pisodes.  Review of the Medic (Market William) and the pisodes.  Review of the Medic (Market William) and the pisodes.  Review of the Medic (Market William) and the pisodes.  Review of the July same medications of (10/21/08).  Review of the July same medications of (10/21/108).  The clinical record resident received the hypertension as ord Review of the resident received the hypertension received the hy	arded the resident as ecision-making.  Iterly Minimum Data Set (MDS) ated 7/12/11, recorded the finterview for Mental Status that indicated moderately and required limited off for activities of daily living.  Iterly Minimum Data Set (MDS) ated 7/12/11, recorded the finterview for Mental Status that indicated moderately and required limited off for activities of daily living.  Iterly Blan of care, dated ed the resident with syncopal dent's behavior monitoring 011, recorded the resident with exact on Administration Record 2011 documented physician decay and Carvedilol, 25 milligrams retension (dated 10/21/08), milligram capsule daily for 19) and Torsemide, 20 hypertension (dated 2011 MAR recorded these renewed by the physician on sident returned from the revealed staff documented the	F 329			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E473	B. WING		07/27/2011	
	ROVIDER OR SUPPLIER	cu	STREET ADDRESS, CITY, STATE, ZIP CODE  128 S PEARSON AVE  WAVERLY, KS 66871			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 329	Continued From pa	ge 33	F 329			
	2011, signed by the	ician' order sheet, dated June physician, lacked evidence of monitoring the residents				
	"standing" physiciar These standing ord	ent's clinical record revealed n orders, signed 5/13/11. ers lacked information oring of the resident's blood ble medications for				
	vital sign parameter than 90 = to be repo	y provided undated rmation labeled KDHE Physer, sheet recorded systolic less orted to physician. However, of care does not address				
	hypertensive medic	a policy to address duplicate ations. The policy only e psychotropic medications.				
	Handbook for Nursi following nursing ac "Carvedilol (be activity) pages 237-interactions with oth that will effect blood tests, therapeutic ethypertension, reduce response (e.g. cong Cardizem (antiblocker) pages 422-monitor therapeutic use (hypertension, see the second control of the s	ta blocker with alpha-blocking 239, assess potential for ner prescriptionsanything I pressure. Monitor laboratory				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE COMF	SURVEY
		17E473	B. WING		07/	27/2011
	ROVIDER OR SUPPLIER	eu		STREET ADDRESS, CITY, STATE, ZIP CODE  128 S PEARSON AVE  WAVERLY, KS 66871		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 329	actions included -motherapeutic effective (e.g. dehydration, elepostural hypotension therapy."  During an interview, licensed nursing staff had not given specific resident's pulse or bimedications for hypotherapy was for this staff M reported the and resident blood pmonthly.  The facility failed to emedication regimen or duplicative medication regimen or duplicative medication record physician orders for Coumadin, 2 milligradeep vein thrombosi Coumadin, 2.5 milligradeep vein thrombosi Co	diuretic) pages 1427-1428, initor laboratory tests, ness, and adverse response extrolyte imbalance e, i) on a regular basis during  on 7/25/11 at 12:40 P.M., if M reported the physician c parameters regarding the lood pressure with multiple extension or what the goal of resident. Licensed nursing facility uses standing orders ressures were monitored  ensure this resident's was free from unnecessary ations by failure to adequately is blood pressure for side id duplicate drug therapy.  Int's medication as follows: ms daily, blood thinner for s (DVT) (dated 6/9/11), rams daily (changed on 0 milligrams, 2 tablets as burs (6/2/11) and Tylenol, grams, one per rectum every	F 32	9		
	Tylenol (acetaminop					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E473	B. WING		07/27/2011
	ROVIDER OR SUPPLIER	си		STREET ADDRESS, CITY, STATE, ZIP CODE  128 S PEARSON AVE  WAVERLY, KS 66871	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 329	recorded "A Boxed potential for severe highlighting the pote (swelling of the face breathing, itching, of the Le		F 32	9	
	U.S. Boxed Warning bleeding.  On 7/25/11 at 1:45 confirmed the reside Coumadin for a DV	s for Coumadin recorded the g: may cause major or fatal  P.M., licensed nursing staff I ent received the medication  T.  P.M., licensed nursing staff M			
	revealed the consul medications, advers facility an entire list Warnings. Review of the facilit resident care plan b	ting pharmacist reviewed all se reactions and provided the of medications with Black Box  y listed medications in the ooks, lacked evidence of the			
	and Coumadin.  The facility failed to resident for adverse boxed warning for T Coumadin.  Review of resider Administration Recorded a physicia	identify and monitor this reactions related to the ylenol (acetaminophen) and the #12's Medication ord (MAR), dated July 2011, norder, dated 4/1/11, to 325 milligrams, two tables			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		17E473	B. WING		07/27/2011	
NAME OF PROVIDER OR SUPPLIER  COFFEY COUNTY HOSPITAL LTCU			STREET ADDRESS, CITY, STATE, ZIP CODE  128 S PEARSON AVE  WAVERLY, KS 66871		1 0//2//2011	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 329	Review of the reside evidence of the boxe resident's plan of care of the consult medications, advers facility an entire list of Warnings.  Review of the facility resident care plan be Black Box Warning facility and the FD. Administration) Med recorded "A Boxed of potential for severe highlighting the pote (swelling of the face breathing, itching, or	ent's clinical record lacked ed warning for Tylenol on the re.  P.M., licensed nursing staff M ing pharmacist reviewed all e reactions and provided the of medications with Black Box of listed medications in the poks, lacked evidence of the for Tylenol (acetaminophen).	F 329	· · · · · · · · · · · · · · · · · · ·		
	- The facility admitted with diagnoses inclusionstructive chronic be esophageal reflux, numellitus, type II, dep	ed resident # 37 on 7/13/10 ding vascular dementia, pronchitis, atrial fibrillation, nyocardial infarction, diabetes ression, hypertension, iovascular disease, and				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		17E473	B. WING		07/27/2011		
NAME OF PROVIDER OR SUPPLIER  COFFEY COUNTY HOSPITAL LTCU			STREET ADDRESS, CITY, STATE, ZIP CODE  128 S PEARSON AVE  WAVERLY, KS 66871		,		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION		
F 329	to administer the foll  1. Tylenol, 500mg, a by mouth every 4 ho 2. Hytrin, an anti-hy twice daily and chec pressure prior to adr 3. Verapamil, an an and check [the resid administration. 4. Metoprolol, an ar mouth, daily, and ch pressure prior to adr 5. Isosorbide Monor 60mg, by mouth, da  Additionally, on 9/16  ES (Extra Strength) 2 tabs, by mouth, tw  A pharmacy consulta identified the recome the physician, regard Seroquel. At that tin refused/declined any psychotropic medica resident as, "Stable, record, subsequently recommendations for reduction.)  A comprehensive ar set) assessment, da resident with a BIMS	a pain/fever reducer, 1-2 tabs ours, prn (as needed). pertensive, 2mg, by mouth, k [the resident's] blood ministration. ti-depressant, 240mg, daily, ent's] blood pressure prior to nti-hypertensive, 50mg, by eck [the resident's] blood ministration. hitrate, an anti-hypertensive, illy.  1/10, the physician ordered:  Tylenol, a pain/fever reducer, ice daily, for arthritis.  2/10, mendation/ consideration to ding long term use of	F 329				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		17E473	B. WING		07/27/2011	
NAME OF PROVIDER OR SUPPLIER  COFFEY COUNTY HOSPITAL LTCU			STREET ADDRESS, CITY, STATE, ZIP CODE  128 S PEARSON AVE  WAVERLY, KS 66871		1 01/21/2011	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 329	An FDA (Federal Dr. MedWatch, dated 1 warning highlighting injury and a potentia (swelling of the face breathing, itching, or label of all prescript acetaminophen."  Furthermore, the far resident with hypert medications for trea with orders to monit pressure, prior to ac facility failed to obtablood pressure paraphysician.  Review of the July, Administration Recommitored the reside ordered. However, physician on one or resident's blood premmhg (millimeters of linterview, with certif at 10:10 a.m., repopressure is monitored the resider monitoring the certif believed the resider normal for the resider or physician notification.	d 7/5/11, failed to identify the or Tylenol.  rug Administration), /13/11, identified, "A boxed of the potential for severe liver all for allergic reactions of the mouth, and throat, difficulty or rash) will be added to the ion drug products that contain collity obtained orders for this tension, to receive multiple of the hypertension, for the resident's blood diministration. However, the initial clarification orders, to set ameters for notification of the collin clarified the staff tent's blood pressure, as the facility failed to notify the collin collin to the collin	F 329			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		17E473	B. WING		07/27/2011	
NAME OF PROVIDER OR SUPPLIER  COFFEY COUNTY HOSPITAL LTCU		STREET ADDRESS, CITY, STATE, ZIP CODE  128 S PEARSON AVE  WAVERLY, KS 66871		1 37/21/2011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 329	Continued From pa	ge 39	F 329			
	documentation informal Physer, directed state pressure greater the pressure routinely gresident's physician					
	_					
	physician of an eleving failed to alert the rebox warnings associated	monitor and notify the vated blood pressure, and sponsible staff to the black ciated with the use of such required those warnings.				
	who received medic warnings, failed to i resident related to a side effects associa	cations with black box dentify any monitoring of the adverse reactions and/or the ted with the black box cted the following residents:				
	2/27/04, ordered Actablets, by mouth, the osteoarthritis; Furos mouth, for hyperten Acetaminophen sup	semide, 80mg, daily, by sion, ordered 9/25/06; and opository, 650mg, per rectum, hours, for pain and/or				
	warning highlighting	rug Administration), /13/11, identified, "A boxed g the potential for severe liver al for allergic reactions				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′		(X3) DATE SURVEY COMPLETED		
	17E473	B. WING		07/27/2011		
NAME OF PROVIDER OR SUPPLIER  COFFEY COUNTY HOSPITAL LTCU			28 S PEARSON AVE	, 0,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION		
(swelling of the face breathing, itching, or label of all prescript acetaminophen."  The Drug Informatic 2011, page 649, ide [ U.S Boxed Warnin amounts, Furosemi diuretics, can lead to in fluid and electroly 2. Resident #28: F5/5/10, the physicia 650mg, by mouth oneeded; and on 12/325mg, 1 or 2 tabs, needed.  An FDA (Federal Dr. MedWatch, dated 1 warning highlighting injury and a potentia (swelling of the face breathing, itching, collabel of all prescript acetaminophen."  3. Resident #33: F4/8/11, ordered Furd for congestive heard 500mg, four times of the Drug Informatic 2011, page 649, idea.	e, mouth, and throat, difficulty or rash) will be added to the ion drug products that contain on Handbook for Nursing, entified, "A Warning/Precaution ag]: If given in excessive de, similar to other loop or profound diuresis, resulting yet depletion."  Physician's orders, dated ordered acetaminophen, rectum, every 4 hours, as 19/10 ordered Acetaminophen, by mouth, every 4 hours, as 19/10 ordered Acetaminophen, by mouth, every 4 hours, as 19/10 ordered Acetaminophen, by mouth, every 4 hours, as 19/13/11, identified, "A boxed of the potential for severe liver all for allergic reactions end, and throat, difficulty or rash) will be added to the ion drug products that contain 19/10/15/15/15/15/15/15/15/15/15/15/15/15/15/	F 329				
	CORRECTION  ROVIDER OR SUPPLIER  SUMMARY:  (EACH DEFICIEN REGULATORY O  Continued From pa (swelling of the face breathing, itching, of label of all prescript acetaminophen."  The Drug Informatic 2011, page 649, ide [ U.S Boxed Warnin amounts, Furosemi diuretics, can lead to in fluid and electroly 2. Resident #28: F 5/5/10, the physicia 650mg, by mouth of needed; and on 12/ 325mg, 1 or 2 tabs, needed.  An FDA (Federal Di MedWatch, dated 1 warning highlighting injury and a potentia (swelling of the face breathing, itching, of label of all prescript acetaminophen."  3. Resident #33: F 4/8/11, ordered Fur for congestive hear 500mg, four times of The Drug Informatic 2011, page 649, ide [ U.S Boxed Warnin amounts, Furosemi	CORRECTION  TIPE473  ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 40 (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) will be added to the label of all prescription drug products that contain acetaminophen."  The Drug Information Handbook for Nursing, 2011, page 649, identified, "A Warning/Precaution [ U.S Boxed Warning]: If given in excessive amounts, Furosemide, similar to other loop diuretics, can lead to profound diuresis, resulting in fluid and electrolyte depletion."  2. Resident #28: Physician's orders, dated 5/5/10, the physician ordered acetaminophen, 650mg, by mouth or rectum, every 4 hours, as needed; and on 12/9/10 ordered Acetaminophen, 325mg, 1 or 2 tabs, by mouth, every 4 hours, as needed.  An FDA (Federal Drug Administration), MedWatch, dated 1/13/11, identified, "A boxed warning highlighting the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) will be added to the label of all prescription drug products that contain	CONTIDENTIFICATION NUMBER:  17E473  B. WING  ROVIDER OR SUPPLIER  COUNTY HOSPITAL LTCU  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 40  Continued From page 40  (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) will be added to the label of all prescription drug products that contain acetaminophen."  The Drug Information Handbook for Nursing, 2011, page 649, identified, "A Warning/Precaution [U.S Boxed Warning]: If given in excessive amounts, Furosemide, similar to other loop diuretics, can lead to profound diuresis, resulting in fluid and electrolyte depletion."  2. Resident #28: Physician's orders, dated 5/5/10, the physician ordered acetaminophen, 650mg, by mouth or rectum, every 4 hours, as needed; and on 12/9/10 ordered Acetaminophen, 325mg, 1 or 2 tabs, by mouth, every 4 hours, as needed.  An FDA (Federal Drug Administration), MedWatch, dated 1/13/11, identified, "A boxed warning highlighting the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) will be added to the label of all prescription drug products that contain acetaminophen."  3. Resident #33: Physician's orders, dated 4/8/11, ordered Furosemide, 40mg, twice daily, for congestive heart failure; and Acetaminophen, 500mg, four times daily, for pain on 4/12/11.  The Drug Information Handbook for Nursing, 2011, page 649, identified, "A Warning/Precaution [U.S Boxed Warning]: If given in excessive amounts, Furosemide, similar to other loop	TOUNTY HOSPITAL LTCU  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL RESULATORY OR LSC DENTIFYING INFORMATION)  Continued From page 40 (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) will be added to the label of all prescription drug dreded acetaminophen,  The Drug Information Handbook for Nursing, 2011, page 649, identified, "A boxed warning highlighting the potential for severe liver injury and a potential for allergic reactions, second warning highlighting the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, liching, or rash) will be added to the label of all prescription drug products that contain acetaminophen.  The Drug Information Handbook for Nursing, 2011, page 649, identified, "A Warning/Precaution [U.S Boxed Warning]: If given in excessive amounts, Furosemide, similar to other loop diuretics, can lead to profound diuresis, resulting in fluid and electrolyte depletion."  2. Resident #28: Physician's orders, dated 55/10, the physician ordered acetaminophen, 850mg, by mouth or rectum, every 4 hours, as needed; and on 12/9/10 ordered Acetaminophen, 850mg highlighting the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, liching, or rash) will be added to the label of all prescription drug products that contain acetaminophen."  3. Resident #33: Physician's orders, dated 4/8/11, ordered Furosemide, 40mg, twice daily, for congestive heart failure; and Acetaminophen, 500mg, four times daily, for pain on 4/12/11.  The Drug Information Handbook for Nursing, 2011, page 649, identified, "A Warning/Precaution [U.S Boxed Warning]: If given in excessive amounts, Furosemide, similar to other loop		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '		(X3) DATE SURVEY COMPLETED	
	17E473	B. WING		07/27/2011	
NAME OF PROVIDER OR SUPPLIER  COFFEY COUNTY HOSPITAL LTCU			STREET ADDRESS, CITY, STATE, ZIP CODE  128 S PEARSON AVE  WAVERLY, KS 66871	,	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION	
MedWatch, dated 1/1 warning highlighting to injury and a potential (swelling of the face, breathing, itching, or label of all prescription acetaminophen."  4. Resident #17: Ph 3/17/09, ordered Furdevery a.m., for edemon Acetaminophen, 325 daily for pain.  The Drug Information 2011, page 649, iden [ U.S Boxed Warning amounts, Furosemide diuretics, can lead to in fluid and electrolyte An FDA (Federal Drum MedWatch, dated 1/1 warning highlighting to injury and a potential (swelling of the face, breathing, itching, or label of all prescription acetaminophen."  5. Resident #8: Phys 3/16/10, ordered Furdmouth, for congestive Acetaminophen, 325 every 4 hours, as neetemperature; then on	the potential for severe liver for allergic reactions mouth, and throat, difficulty rash) will be added to the on drug products that contain dysician's orders, dated osemide, 40mg, by mouth, a; and on 2/22/10 ordered mg, by mouth three times in Handbook for Nursing, tiffied, "A Warning/Precaution of the profound diuresis, resulting edepletion."  If given in excessive e, similar to other loop profound diuresis, resulting edepletion."  If administration), 13/11, identified, "A boxed the potential for severe liver for allergic reactions mouth, and throat, difficulty rash) will be added to the on drug products that contain diesician's orders, dated osemide, 40mg, daily, by the heart failure, and mg, 2 tablets, by mouth, eded for pain or elevated 11/23/10 the physician	F 32	9		
	CONTY HOSPITAL LTC  SUMMARY ST (EACH DEFICIENCE REGULATORY OR  Continued From page MedWatch, dated 1/1 warning highlighting injury and a potential (swelling of the face, breathing, itching, or label of all prescription acetaminophen."  4. Resident #17: Ph 3/17/09, ordered Furnevery a.m., for edemondate Acetaminophen, 325 daily for pain.  The Drug Information 2011, page 649, identification fluid and electrolyte An FDA (Federal Drug MedWatch, dated 1/1 warning highlighting injury and a potential (swelling of the face, breathing, itching, or label of all prescription acetaminophen."  5. Resident #8: Phys 3/16/10, ordered Furnmouth, for congestive Acetaminophen, 325 every 4 hours, as needed 325mg, by mouth every summouth	CORRECTION  IDENTIFICATION NUMBER:  17E473  ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 41  MedWatch, dated 1/13/11, identified, "A boxed warning highlighting the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) will be added to the label of all prescription drug products that contain acetaminophen."  4. Resident #17: Physician's orders, dated 3/17/09, ordered Furosemide, 40mg, by mouth, every a.m., for edema; and on 2/22/10 ordered Acetaminophen, 325mg, by mouth three times daily for pain.  The Drug Information Handbook for Nursing, 2011, page 649, identified, "A Warning/Precaution [U.S Boxed Warning]: If given in excessive amounts, Furosemide, similar to other loop diuretics, can lead to profound diuresis, resulting in fluid and electrolyte depletion."  An FDA (Federal Drug Administration), MedWatch, dated 1/13/11, identified, "A boxed warning highlighting the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) will be added to the label of all prescription drug products that contain	CORRECTION  IDENTIFICATION NUMBER:  A. BUILDING  B. WING  B. WING  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 41  MedWatch, dated 1/13/11, identified, "A boxed warning highlighting the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) will be added to the label of all prescription drug products that contain acetaminophen."  4. Resident #17: Physician's orders, dated 3/17/09, ordered Furosemide, 40mg, by mouth, every a.m., for edema; and on 2/22/10 ordered Acetaminophen, 325mg, by mouth three times daily for pain.  The Drug Information Handbook for Nursing, 2011, page 649, identified, "A Warning/Precaution [U.S Boxed Warning]: If given in excessive amounts, Furosemide, similar to other loop diuretics, can lead to profound diuresis, resulting in fluid and electrolyte depletion."  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Resident #8: Physician's orders, dated 3/16/10, ordered Furosemide, 40mg, daily, by mouth, for congestive heart failure, and Acetaminophen, 325mg, 2 tablets, by mouth, every 4 hours, as needed for pain or elevated temperature; then on 11/23/10 the physician added an as needed order for Acetaminophen, 325mg, by mouth every 4 hours, as needed for	TREATS  TOUNTY HOSPITAL LTCU  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)  Continued From page 41  MedWatch, dated 1/13/11, identified, "A boxed warning highlighting the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) will be added to the label of all prescription drug products that contain acetaminophen."  The Drug Information Handbook for Nursing, 2011, page 649, identified, "A boxed warning highlighting to there loop diuretics, can lead to profound diuresis; resulting in fluid and electrolyte depletion."  A. Boxed Warning!: If given in excessive amounts, Furosemide, similar to other loop diuretics, can lead to profound diuresis; resulting in fluid and electrolyte depletion."  A. Box ident #8: Physician's orders, dated analyte for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, inching, or rash) will be added to the label of all prescription drug products that contain acetaminophen, 325mg, 2 tablets, by mouth, every 4 hours, as needed for pain or elevated temperature; then on 11/23/10 the physician added an as needed order for Acetaminophen, 325mg, 9 mouth every 4 hours, as needed for pain or elevated temperature; then on 11/23/10 the physician added an as needed order for Acetaminophen, 325mg, 9 mouth every 4 hours, as needed for	

PRINTED: 08/12/2015 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X	(X3) DATE SURVEY COMPLETED	
		17E473	B. WING			07/27	7/2011
	ROVIDER OR SUPPLIER COUNTY HOSPITAL LTC	U		STREET ADDRESS, CITY, STATE, ZIP CODE  128 S PEARSON AVE  WAVERLY, KS 66871			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
F 428 SS=E	warning highlighting to injury and a potential (swelling of the face, breathing, itching, or label of all prescription acetaminophen."  The Drug Information 2011, page 649, identiful and electrolytes amounts, Furosemided diuretics, can lead to in fluid and electrolytes. The facility failed to madverse reactions and medications with blace 483.60(c) DRUG REGIRREGULAR, ACT OF The drug regimen of reviewed at least once pharmacist.  The pharmacist must the attending physician ursing, and these results of the facility identified with 11 residents same	g Administration), 13/11, identified, "A boxed the potential for severe liver for allergic reactions mouth, and throat, difficulty rash) will be added to the on drug products that contain  Handbook for Nursing, tified, "A Warning/Precaution ]: If given in excessive e, similar to other loop profound diuresis, resulting e depletion." nonitor these residents for d/or side effects for ck box warnings. GIMEN REVIEW, REPORT		428		8	3/12/11

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		17E473	B. WING		07/27/2011
NAME OF PROVIDER OR SUPPLIER  COFFEY COUNTY HOSPITAL LTCU			STREET ADDRESS, CITY, STATE, ZIP CODE  128 S PEARSON AVE  WAVERLY, KS 66871	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 428	nursing 10 of 10 resi #(9 and 27) for moni pressures with parar medications; resider after the physician o residents # (4,8,9.12 lacked monitoring fo Black Box Warning a  Findings included:  - According to the c admitted resident #9  Review of the Physic June 2011, recorded hypertension, atrial- congestive heart fail disease, erosive esc of myocardial infarct  Review of the Medic (MAR), dated July 2 orders that included daily for hypertensio 0.125 milligrams dai (dated 1/15/10), Las daily in the morning (dated 7/24/09), Tyle with Ultram (a pain r Noon for arthritis (da milligrams, 2 tablets (dated 4/2/08).  The plan of care, da resident received La the resident's plan o	the physician and/or director dents that included residents toring pulse and blood meters for duplicative cardiac at #24 a medication continued redered it discontinued; and 2, 17, 27, 28, 33 and 37) who are adverse side effects on advisements.  Ilinical record, the facility 1, on 9/19/05.	F 4:	28	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG		OATE SURVEY OMPLETED
		17E473	B. WING _			07/27/2011
NAME OF PROVIDER OR SUPPLIER  COFFEY COUNTY HOSPITAL LTCU			STREET ADDRESS, CITY, STATE, ZIP CODE  128 S PEARSON AVE  WAVERLY, KS 66871	<b>'</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 428	recorded "A Boxed V potential for severe li highlighting the poten (swelling of the face, breathing, itching, or According to Lexi-Co for Nursing, 12th Edi (U.S. Boxed Warning given in excessive air to other loop diuretical diuresis, resulting in depletion.  On 7/21/11 at 3:00 P revealed the consulting medications, adverse facility an entire list of Warnings.  Review of the facility resident care plan be Black Box Warning for and Lasix (furosemical Con 7/26/11 at 4:45 P reported a general di involving Black Box V medications were ad laboratory testing who with the initiation of the swelling in the potential of the several conditions.	A (Food and Drug Watch, dated 1/13/11, Warning highlighting the ver injury and a Warning nitial for allergic reactions mouth, and throat, difficulty rash) for acetaminophen.  Imp Information Handbook tion, page 649, recorded a p) for Lasix (furosemide), if mounts, furosemide, similar s, can lead to profound fluid and electrolyte  I.M., licensed nursing staff M ng pharmacist reviewed all e reactions and provided the firmedications with Black Box  Ilisted medications in the tooks, lacked evidence of the or Tylenol (acetaminophen) Tylenol (acetaminophen) Tylenol (acetaminophen) Tylenol with the facility Warnings and that the equately monitored with the ich automatically triggered	F 4	28		
	received the Toprol X as ordered.	(L, Digoxin, Lasix and Tylenol				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTR	.UCTION	(X3) DATE SURVEY COMPLETED			
		17E473	B. WING _				07/27/2011	
NAME OF PROVIDER OR SUPPLIER  COFFEY COUNTY HOSPITAL LTCU				STREET ADDRESS, CITY, STATE, ZIP CODE  128 S PEARSON AVE  WAVERLY, KS 66871				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 428	Continued From page	e 45	F4	128				
		vealed staff documented the to administration of the						
	The resident's MAR/o evidence of physician monitoring the reside digoxin.							
	licensed nursing staff not aware the resider Administration Record residents pulse prior Toprol XL or digoxin. continued that the infethe resident's pulse with the resident the resident that the resident	d lacked parameters for the to administration of the Licensed nursing staff M formation for parameters on was not on the physician's staff use the "standard" for						
	reported the facility pa	.M., direct care staff H arameter for holding the as less than 60 beats per						
	acknowledged that st resident's pulse prior medication and that the	.M., pharmacy consultant AA traff should monitor the to administration of these he medication administration the physician defined esident's pulse.						
		nation labeled KDHE Physer, t a resting pulse less than						
	The facility lacked a p	policy regarding consistent						

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		PLE CONSTRUCTION  IG	· ,	(X3) DATE SURVEY COMPLETED	
		17E473	B. WING _			7/27/2011	
NAME OF PROVIDER OR SUPPLIER  COFFEY COUNTY HOSPITAL LTCU			STREET ADDRESS, CITY, STATE, ZIP COI 128 S PEARSON AVE WAVERLY, KS 66871				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 428	rate with administratic congestive heart failured to explain the facility failed to explain the facility administration.  Review of the facility failed to explain the facility administration.  Review of the Physic June 2011 and signed 6/15/11, recorded dia dementia, hypertensic factory disease, depression and the facility failed the facility failed to the facility facility admitted resident disease, depression for the facility failed the facility failed to the facility failed the facility failed to the failed	onitoring of resident heart on of medications for are and antihypertensives.  Insure the consulting and reported the need for a parameters for this resident diac medications.  Insure the consulting the staff need for Black Box are consequences associated in of these medications.  Ity face sheet, recorded the ent #27 on 1/16/08.  Itan's Order Sheet, dated do by the physician on gnoses that included: on, osteoporosis, coronary sision and age-related in.  Irea Assessment (CAA), and the resident as a dision-making.  Ity Minimum Data Set (MDS) and 7/12/11, recorded the interview for Mental Status and indicated moderately	F 4	28			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		17E473	B. WING		07/27/2011
	NAME OF PROVIDER OR SUPPLIER  COFFEY COUNTY HOSPITAL LTCU			STREET ADDRESS, CITY, STATE, ZIP CODE  128 S PEARSON AVE  WAVERLY, KS 66871	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 428	sheet, dated July 201 black out episodes.  Review of the Medica (MAR) dated June 20 orders that included: twice daily for hyperte Diltiazem ER, 300 mi hypertension (8/4/09) milligrams daily for hy 10/21/08).  Review of the July 20 same medications rere 6/2/11 when the residence of the comparison of the July 20 same medications reresident received the hypertension as orderesident received the hypertension as orderesident resident resident Faxed Communication 6/28/11, (untimed) that syncope while ambulated and the resident's bloom Review of the physician orders for medical physician physician orders for medical physician physician orders for medical physician physician physician physician physician physician physician physician physi	at's behavior monitoring 1, recorded the resident with  ation Administration Record 11 documented physician Carvedilol, 25 milligrams ension (dated 10/21/08), Iligram capsule daily for and Torsemide, 20 Apertension (dated  11 MAR recorded these newed by the physician on ent returned from the  Avealed staff documented the medications for ared by the physician, at's clinical record revealed a an for to the physician, dated at the resident experienced ating with a staff member od pressure was 86/61.  an's order sheet, dated June hysician, lacked evidence of monitoring the residents  at's clinical record revealed by the physician of the residents  at's clinical record revealed by the physician of the residents  at's clinical record revealed by the physician of the resident's blood at the resident's blood at the resident's blood at the resident's blood at the resident's blood and the resident's blood	F 428	В	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		17E473	B. WING		07/27/2011
	ROVIDER OR SUPPLIER	CU		STREET ADDRESS, CITY, STATE, ZIP CODE  128 S PEARSON AVE  WAVERLY, KS 66871	·
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION
F 428	Continued From pag	ge 48	F 42	8	
1 420	documentation informatical sign parameter than 90 = to be reported the MAR and plan or parameters.  The facility lacked a hypertensive medical addressed duplicate addressed duplicate addressed duplicate activity) pages 237-22 interactions with other that will effect blood tests, therapeutic eff hypertension, reductives pages 422-monitor therapeutic use (hypertension, a or paroxysmal suprates).  Torsemide (loop actions included -montherapeutic effective (e.g. dehydration, elections included).	mation labeled KDHE Physer, sheet recorded systolic less arted to physician. However, of care does not address duplicate ations. The policy only psychotropic medications.  Acti-Comp Drug Information and address diplicate the tions:  The policy only psychotropic medications.  The policy only psychotropic medications.	F 42		
	licensed nursing star had not given specif resident's pulse or b	on 7/25/11 at 12:40 P.M.,  ff M reported the physician  ic parameters regarding the  lood pressure with multiple			
		ertension or what the goal of resident. Licensed nursing			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E473	B. WING _			07/	/27/2011	
	ROVIDER OR SUPPLIER	J		STREET ADDR 128 S PEARS WAVERLY, I		•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD I ROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 428	staff M reported the fa and resident blood pr monthly.  On 7/26/11 at 4:45 P. acknowledged that the reevaluation for the necontrol blood pressure. The facility failed to expharmacist identified consistent monitoring resident that received medications  Review of the resider administration record physician orders for the Coumadin, 2 milligrar deep vein thrombosis Coumadin, 2.5 m	M., pharmacy consultant AA e resident needed eed of 3 medications to e.  Insure the consulting and reported the need for and parameters for this I multiple blood pressure  Insufe the dication as follows: Insure the consulting and reported the need for and parameters for this I multiple blood pressure  Insure the consulting and reported the need for and parameters for this I multiple blood pressure  Insure the consulting and reported the need for and parameters for this I multiple blood pressure  Insure the consulting and reported the need for things for things for things for Coumadin or en).  Insure the consulting and reported the need for things for Coumadin or en).	F	128				
	temperature.  Review of the clinical any Black Boxed War Tylenol (acetaminoph According to the FDA Administration) MedV recorded "A Boxed W potential for severe livinghlighting the poten (swelling of the face,	record lacked evidence of rnings for Coumadin or en).  (Food and Drug Vatch, dated 1/13/11, /arning highlighting the ver injury and a Warning tial for allergic reactions						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		17E473	B. WING _			07/27/2011		
	ROVIDER OR SUPPLIER	cu		STREET ADDRESS, CITY, STATE, ZIP CODE 128 S PEARSON AVE WAVERLY, KS 66871	·			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 428	Continued From pag	e 50	F 4	28				
	Handbook for Nursin Warning/Precautions U.S. Boxed Warning bleeding.	i-Comp Drug Information ig, 12th Edition, page 1497, is for Coumadin recorded the : may cause major or fatal						
		P.M., licensed nursing staff I nt received the medication :						
	revealed the consulti medications, adverse	at 3:00 P.M., licensed nursing staff M e consulting pharmacist reviewed all s, adverse reactions and provided the ntire list of medications with Black Box						
	resident care plan bo	listed medications in the boks, lacked evidence of the or Tylenol (acetaminophen)						
	reported a general d involving Black Box v medications were ad	P.M., pharmacy consultant AA iscussion with the facility Warnings and that the lequately monitored with the nich automatically triggered hese medications.						
	pharmacist identified							
	recorded a physician	#12's Medication rd (MAR), dated July 2011, order, dated 4/1/11, to 825 milligrams, two tables						

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING		(X3) DATE SURVEY COMPLETED			
		17E473	B. WING		07/27/2011
	PROVIDER OR SUPPLIER	cu		STREET ADDRESS, CITY, STATE, ZIP CODE  128 S PEARSON AVE  WAVERLY, KS 66871	, 0,,2,,20,,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 428	orally, twice daily for Review of the clinical received the medical.  Review of the reside evidence of the boxeresident's plan of car.  On 7/21/11 at 3:00 Frevealed the consult medications, advers facility an entire list of Warnings.  On 7/26/11 at 4:45 Freported a general dinvolving Black Box medications were aclaboratory testing which with the initiation of the Review of the facility resident care plan be Black Box Warning for According to the FD. Administration) Medirecorded "A Boxed Wighting the pote (swelling of the face) breathing, itching, or The facility failed to opharmacist identified Warnings with adver with the administration.	"all-over-pain". Il record revealed the resident tion as ordered. Int's clinical record lacked ed warning for Tylenol on the re.  P.M., licensed nursing staff M ing pharmacist reviewed all e reactions and provided the of medications with Black Box  P.M., pharmacy consultant AA iscussion with the facility Warnings and that the lequately monitored with the nich automatically triggered these medications.  I listed medications in the books, lacked evidence of the for Tylenol (acetaminophen).	F 428	3	

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED			
		17E473	B. WING		07/27/2011	
	ROVIDER OR SUPPLIER	cu	1:	TREET ADDRESS, CITY, STATE, ZIP CODE 28 S PEARSON AVE VAVERLY, KS 66871	1 01/2/12011	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION	
F 428	obstructive chronic esophageal reflux, mellitus, type II, dep hyperlipidemia, care persistent mental depressive the foot administer the foot administration and check [the residual and check [the residual administration.  4. Metoprolol, an amouth, daily, and observe prior to administration.  4. Metoprolol, an amouth, daily, and observe prior to administration.  4. Metoprolol, an amouth, daily, and observe prior to administration.  4. Metoprolol, an amouth, daily, and observe prior to administration.  4. Metoprolol, an amouth, daily, and observe prior to administration.  4. Metoprolol, an amouth, daily, and observe prior to administration.  4. Metoprolol, an amouth, daily, and observe prior to administration.  4. Metoprolol, an amouth, daily, and observe prior to administration.  4. Metoprolol, an amouth, daily, and observe prior to administration.  4. Metoprolol, an amouth, daily, and observe prior to administration.  4. Metoprolol, an amouth, daily, and observe prior to administration.  4. Metoprolol, an amouth, daily, and observe prior to administration.  4. Metoprolol, an amouth, daily, and observe prior to administration.  4. Metoprolol, an amouth, daily, and observe prior to administration.  4. Metoprolol, an amouth, daily, and observe prior to administration.  4. Metoprolol, an amouth, daily, and observe prior to administration.  4. Metoprolol, an amouth, daily, and observe prior to administration.  4. Metoprolol, an amouth, daily, and observe prior to administration.	uding vascular dementia, bronchitis, atrial fibrillation, myocardial infarction, diabetes pression, hypertension, diovascular disease, and isorder.  ated 7/13/10, instructed staff llowing medications:  a pain/fever reducer, 1-2 tabs ours, prn (as needed). ypertensive, 2mg, by mouth, ck [the resident's] blood liministration. Inti-depressant, 240mg, daily, dent's] blood pressure prior to inti-hypertensive, 50mg, by heck [the resident's] blood liministration. Inti-hypertensive, an anti-hypertensive, aily.  6/10, the physician ordered:  1 Tylenol, a pain/fever reducer, wice daily, for arthritis.  tant report, dated 9/29/10, inmendation/ consideration to riding long term use of	F 428			

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING  A. BUILDING		(X3) DATE SURVEY COMPLETED			
		17E473	B. WING		07/27/2011	
	ROVIDER OR SUPPLIER	cu		STREET ADDRESS, CITY, STATE, ZIP CODE 128 S PEARSON AVE WAVERLY, KS 66871	1 01/21/2011	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 428	Continued From pa	ge 53	F 428	3		
	set) assessment, d resident with a BIM status) score of 11, impairment.	-				
	MedWatch, dated 1 warning highlighting injury and a potenti (swelling of the face breathing, itching, of	/13/11, identified, "A boxed g the potential for severe liver al for allergic reactions e, mouth, and throat, difficulty or rash) will be added to the tion drug products that contain				
	resident with hyper medications for trea with orders to moni pressure, prior to a facility failed to obta	cility obtained orders for this tension, to receive multiple atment of the hypertension, tor the resident's blood dministration. However, the ain clarification orders, to set ameters for notification of the				
	monitored the resid ordered. However, physician on one or	ord, identified the staff lent's blood pressure, as the facility failed to notify the ccasion, on 7/9/11, when the essure measured 200/112				
	at 10:10 a.m., repo	fied nursing staff H, on 7/25/11 orted the resident's blood ed daily before administering				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		E SURVEY PLETED
		17E473	B. WING _		07	//27/2011
	ROVIDER OR SUPPLIER	U	,	STREET ADDRESS, CITY, STATE, ZIP CODE  128 S PEARSON AVE  WAVERLY, KS 66871		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 428	monitoring the certific believed the resident normal for the reside for physician notificat nursing documentation notification to the physician to the physician of the facility documentation inform Physer, directed staff pressure greater than pressure routinely gresident's physician.	nedication. If during the ed medication nursing staff 's blood pressure to be out of nt then the nurse is notified, tion. Documentation in the on on that date, lacked such visician.  provided, undated, nation, labeled, KDHE of to report a systolic blood on 200 and a diastolic blood eater than 90 to the	F4	28		
	approximately 4:45 p conducted monthly, sadmission, should hap arameters for blood notification to the phyreported the facility adiscussed, in genera he/she felt the medic monitored with labora automatically triggere medications, as relate Furosemide.  - Review of the clinic who received medications, failed to identify the conductions of the clinic warnings, failed to identify the conductions of the clinic warnings, failed to identify the conductions of the clinic warnings, failed to identify the conduction of the clinic warnings, failed to identify the conduction of the clinic warnings, failed to identify the conduction of the clinic warnings, failed to identify the conduction of the clinic warnings, failed to identify the conduction of the clinic warnings, failed to identify the conduction of the clinic warnings.	ave identified the lack of pressure abnormalities with visician. Additionally, staff AA and the pharmacist consultant II, the black box warnings and ations had been adequately atory testing which led with the initiation of the led to Acetaminophen and leal records, for resident's				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		17E473	B. WING		07/27/2011
	ROVIDER OR SUPPLIER	eu	12	REET ADDRESS, CITY, STATE, ZIP CODE 8 S PEARSON AVE AVERLY, KS 66871	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 428	warnings. This affect  1. Resident # 4: Ph 2/27/04, ordered Ace tablets, by mouth, th osteoarthritis; Furose mouth, for hypertens Acetaminophen supp as needed, every 4 h increased fever, orde  An FDA (Federal Dru MedWatch, dated 1/ warning highlighting injury and a potentia (swelling of the face, breathing, itching, or label of all prescriptic acetaminophen."  The Drug Information 2011, page 649, ider [ U.S Boxed Warning amounts, Furosemid diuretics, can lead to in fluid and electroly 2. Resident #28: Ph 5/5/10, the physician 650mg, by mouth or needed; and on 12/9 325mg, 1 or 2 tabs, in needed.  An FDA (Federal Dru MedWatch, dated 1/ warning highlighting injury and a potentia	ed with the black box sted the following residents:  ysician's orders, dated etaminophen, 500mg, 2 ree times daily, for emide, 80mg, daily, by sion, ordered 9/25/06; and pository, 650mg, per rectum, nours, for pain and/or ered 10/18/06.  Ag Administration), 13/11, identified, "A boxed the potential for severe liver of for allergic reactions mouth, and throat, difficulty rash) will be added to the fon drug products that contain the Handbook for Nursing, antified, "A Warning/Precaution of the profound diuresis, resulting the depletion."  The profound diuresis, resulting the depletion."  The profound diuresis, dated ordered acetaminophen, rectum, every 4 hours, as 1/10 ordered Acetaminophen, on y mouth, every 4 hours, as	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		17E473	B. WING			7/27/2011	
	ROVIDER OR SUPPLIER	eu		STREET ADDRESS, CITY, STATE, ZIP CO 128 S PEARSON AVE WAVERLY, KS 66871		-	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 428	label of all prescription acetaminophen."  3. Resident #33: Pt 4/8/11, ordered Furo for congestive heart 500mg, four times do The Drug Information 2011, page 649, ider [U.S Boxed Warning amounts, Furosemid diuretics, can lead to in fluid and electrolyt An FDA (Federal Drum Med Watch, dated 1/2 warning highlighting injury and a potential (swelling of the face, breathing, itching, or label of all prescription acetaminophen."  4. Resident #17: Pt 3/17/09, ordered Furevery a.m., for edem Acetaminophen, 325 daily for pain.  The Drug Information 2011, page 649, ider [U.S Boxed Warning amounts, Furosemid diuretics, can lead to in fluid and electrolyt An FDA (Federal Drum for content of the cont	rash) will be added to the on drug products that contain hysician's orders, dated semide, 40mg, twice daily, failure; and Acetaminophen, aily, for pain on 4/12/11.  In Handbook for Nursing, htified, "A Warning/Precaution of the loop of profound diuresis, resulting edepletion."  In Gamma and throat, difficulty rash) will be added to the on drug products that contain hysician's orders, dated osemide, 40mg, by mouth, a; and on 2/22/10 ordered mg, by mouth three times  In Handbook for Nursing, htified, "A Warning/Precaution of the loop of the loop."	F 42	28			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION IG			(X3) DATE SURVEY COMPLETED	
		17E473	B. WING _			07	//27/2011	
	ROVIDER OR SUPPLIER	U		128 S	ET ADDRESS, CITY, STATE, ZIP CODE PEARSON AVE ERLY, KS 66871	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 428	Continued From page	e 57	F4	128				
	breathing, itching, or	for allergic reactions mouth, and throat, difficulty rash) will be added to the n drug products that contain						
	mouth, for congestive Acetaminophen, 325 every 4 hours, as nee temperature; then on added an as needed	e heart failure, and mg, 2 tablets, by mouth, eded for pain or elevated 11/23/10 the physician order for Acetaminophen, ery 4 hours, as needed for						
	warning highlighting t injury and a potential (swelling of the face, breathing, itching, or	3/11, identified, "A boxed he potential for severe liver						
	2011, page 649, iden [ U.S Boxed Warning amounts, Furosemide diuretics, can lead to in fluid and electrolyte	nonitor these residents for d/or side effects for						
	AA, reported the facil	m., pharmacist consultant ity and the pharmacist l, in general, the black box						

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DEPLAY OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		17E473	B. WING		07/27/2011
	ROVIDER OR SUPPLIER	cu		STREET ADDRESS, CITY, STATE, ZIP CODE 128 S PEARSON AVE NAVERLY, KS 66871	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 428	been adequately mowhich automatically the medications, as and Furosemide.  - The 11/24/10 physically to administer Menacodaily for an appetite.  The resident's, 2/15/Set) identified the reincluded congestive fatigue, anxiety disornarcolepsy., and car BIMS (Brief Interview 10(8-12 indicates coolons).  On 5/31/11, the pharedocumented; "From of Megace has helpeden intake is 75/Megace could be dismaintain appetite with The physician return and ordered to discoolons. Review of the June 2/MAR (Medication Adithe facility staff continuing Megace 40 milligram to the resident.  On 7/25/11 at 2:55 Fithe letter from the physician return to the resident.	e felt the medications had nitored with laboratory testing triggered with the initiation of related to Acetaminophen  sician order, instructed staff e 40 milligrams, by mouth stimulant.  2011 MDS (Minimum Data sident with diagnosis which heart failure, hypertension, refer, anemia, hypothyroidism, neer without metastasis, with a v for Mental Status) score of gnition moderately impaired)  macy consultant staff dietary notes 3/3/11, the use ed patient with diet intake and dent's weight is stable and 5-100%. Consider whether scontinued to see if they shout the drug."  ed the letter signed 6/25/11, intinue the medication.	F 428		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURY COMPLETE				
		17E473	B. WING			07/	27/2011
	ROVIDER OR SUPPLIER	U		12	REET ADDRESS, CITY, STATE, ZIP CODE 8 S PEARSON AVE AVERLY, KS 66871		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 428  F 441  SS=F	Continued From page On 7/25/11 at 4:47 Pl explained the staff ov to discontinue the Me On 7/26/11, at 4:45 Pl reported completion of review on 6/29/2011, physician order to disthat the facility staff of medication.  The facility's pharmac identify the irregularit to administer the med physician order to dis 483.65 INFECTION OF SPREAD, LINENS  The facility must estat Infection Control Prografe, sanitary and control prevent the de of disease and infection (a) Infection Control From (b) Infection Control From (c) Infection Control From (c) Infection Control From (d) Infection Control From (e) Infection Control From (e) Infection Control From (f) Infection Control	M, licensed nurse K, verlooked the physician order egace.  M, pharmacy consultant AA, of the facility drug regimen and failed to see that the econtinue the medication and continued to administer the cist consultant failed to ies of the facility continuation dication following the econtinue the Megace.  CONTROL, PREVENT  Ablish and maintain an gram designed to provide a mfortable environment and evelopment and transmission ion.  Program ablish an Infection Control	F	441			8/12/11
	in the facility; (2) Decides what proshould be applied to (3) Maintains a record actions related to infection (b) Preventing Spread (1) When the Infection	d of Infection					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED	
		17E473			07/27/2011		
NAME OF PROVIDER OR SUPPLIER  COFFEY COUNTY HOSPITAL LTCU			STREET ADDRESS, CITY, STATE, ZIP C 128 S PEARSON AVE WAVERLY, KS 66871		·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 441	Continued From page 60 prevent the spread of infection, the facility must isolate the resident.  (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.  (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.		F 4	41			
	by: The facility reported Based on observation interview, the facility infection control in the spread of infections to Furthermore, the facility maintain an infection included staff/resider the prevention of infection susceptible population Findings included:  - Observation of wate 3:00 p.m., in the facil staff Y, identified the 147 degrees, Fahren maintenance staff re	failed to ensure proper e laundry to prevent the o the residents of the facility. lity failed to monitor and control program that ht pets or animals to ensure ection or disease in this highly					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		17E473	B. WING		07/27/2011
NAME OF PROVIDER OR SUPPLIER  COFFEY COUNTY HOSPITAL LTCU				STREET ADDRESS, CITY, STATE, ZIP CODE  128 S PEARSON AVE  WAVERLY, KS 66871	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION
F 441	temperature, measure in the laundry area, Fahrenheit.  On 7/25/11 at 1:50 preparature, measure in the laundry area, Fahrenheit. Enviror reported the water that this time due to distinct the laundry was monitored monthly, The staff member further when the water temperatured 160 degree administrator know.  Review of the environmental staff would be monitored the temperatures staff accility failed to water temperatures adequately sanitize development and pothe residents of the Observation during temperatures.	o.m., the laundry water ared at the hand washing sink tested at 142 degrees, o.m., the laundry water ared at the hand washing sink tested at 152 degrees, mental services staff P, emperature, "Might be lower ishwashing on-going [in the "The staff member ter temperatures are by the environmental staff. arther indicated, what staff do perature is below the reported etemperature, "I let my " onmental testing records for dentified the temperature ed 160 degrees, Fahrenheit. oximately 3:30 p.m., P, reported the temperature daily for several days, until abilized at 160 degrees, maintain appropriate hot for laundry services, to and to prevent the otential spread of infections to facility. g the survey on 7/19/11, d 7/25/11 revealed two small	F 44'		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E473	B. WING		07/27/2011	
	NAME OF PROVIDER OR SUPPLIER  COFFEY COUNTY HOSPITAL LTCU			TREET ADDRESS, CITY, STATE, ZIP CODE 28 S PEARSON AVE VAVERLY, KS 66871	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 441	Continued From pag	e 62 A.M., one little white dog	F 441			
	entered the private d	lining 50's room and urinated or door on the carpet runner.				
	licensed nursing state owned by individuals and came with those daily basis. Licensed that the facility kept is Licensed nursing state contacted the hospit the facility fell within provided, did not devanimals or pets.	on 7/21/11 at 1:00 P.M.,  If M reported both dogs, were to that worked at the facility e employees to work on a d nursing staff M continued no files on either animal.  If M reported the facility staff al regarding animals and as the recommendations yelop a policy regarding				
	7/21/11 at 1:18 P.M. revealed one dog wa	h 4, 2011 and distemper				
		P.M., licensed nursing staff M was ill in June and did not immunizations.				
	reported the other do	P.M., administrative staff O, og, was up to date on rabies r, lacked the immunization				
	pets. The facility lacked do immunization and re both dogs observed	gular health examinations of in the facility.				
	1	lines for Environmental Health-Care Facilities;				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E473	B. WING			07/	27/2011	
	ROVIDER OR SUPPLIER	CU	•	12	TREET ADDRESS, CITY, STATE, ZIP CODE 28 S PEARSON AVE VAVERLY, KS 66871			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 441	Control (CDC) and to Control Practices Addated 2003, pages of 2. Animal-Assisted A Therapy, and Reside "Animals participatin Activity (AAA) or Anisessions should be with recommended prophylactic medica prevention) as deterveterinarian based or recommendations. Fanimal's health and Animals should be recompleted antihelmialso be free of ectopticks) and should ha or obvious dermatolassociated with bactinfections or parasitis should be clean and must be supervised animals and their be should be trained in site-specific orientate efficiently with the stenvironment. Addition be in good health. Tinfection-control medisease transmission hand-hygiene meas and water or an alcopatients, staff, and resident in the staff	of Centers for Disease the Healthcare Infection livisory Committee (HICPAC), 106-108, recorded: Activities, Animal-Assisted ent Animals ag in either Animal-Assisted mal-Assisted Therapy (AAT) an good health and up-to-date mmunizations and ations (e.g., heartworm mined by a licensed an local needs and acgular re-evaluation of the abehavior status is essential. activitiely screened for enteric are evidence of a recently anthic regime. They should arasites (e.g., fleas and ave no sutures, open wounds, agic lesions that could be arrial, fungal, or viral ac infestations. Animals activities and receive and these activities and receive and the most important assure to prevent potential an is strict enforcement of ares (e.g., using either soap abolol-based hand rub) for all activities after handling the ad also be taken to avoid	F	441				

Clean-up of these substances from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E473	B. WING		0	07/27/2011	
NAME OF PROVIDER OR SUPPLIER  COFFEY COUNTY HOSPITAL LTCU				STREET ADDRESS, CITY, STATE, ZIF 128 S PEARSON AVE WAVERLY, KS 66871			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 441	use of leak-resistan absorbent material As a general prever programs are advision food preparation kit sterile supply and a supplies, and d) me  The facility failed to maintain an infectio the care and supervensure the prevential	ge 64 Ices requires gloves and the t plastic bags to discard used in the process. Intive measure, resident animal ed to restrict animals from a) chens, b) laundries, c) central my storage areas for clean dication preparation areas."  Implement, monitor and my control program regarding vision of pets and animals to on of infection or disease to all susceptible population, in the	F				